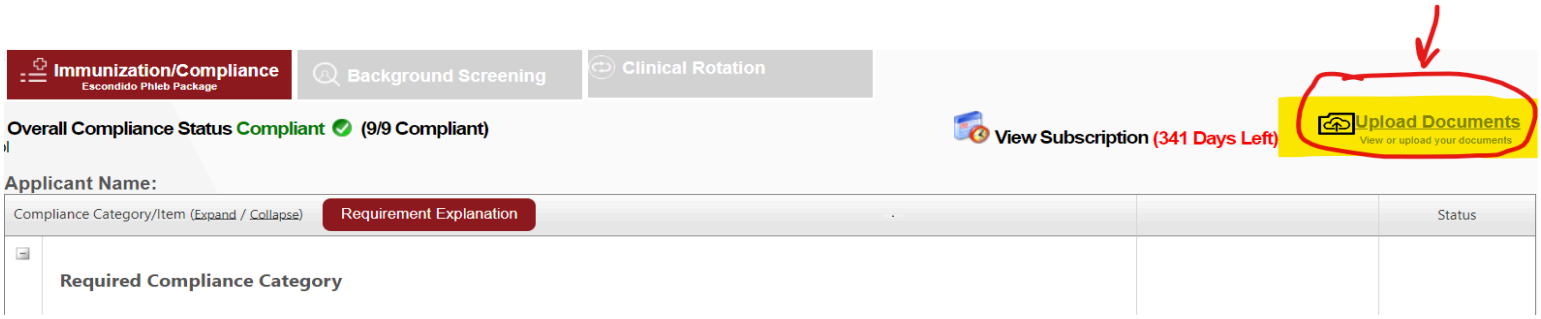
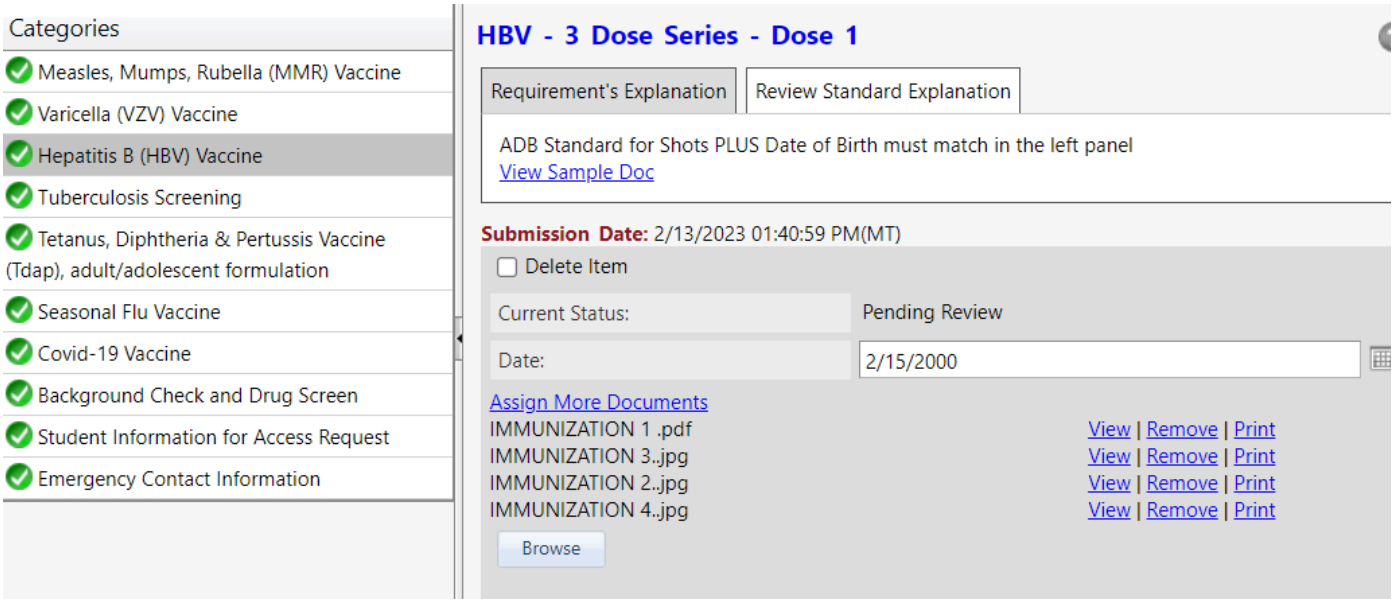
Complio Document Labeling & Uploading Instructions for Medical Assistant Students

As detailed in the clearance guide, you will be uploading documents to your Complio portfolio “document bank” to use in the initial phase of meeting each clearance requirement.



Once you label your documents correctly, make sure to upload **EITHER** the corresponding pages from the Student Health Clearance and Immunization Verification Form **OR** the whole packet to each health clearance and immunization category in Complio.
For TB Negative you need to ONLY include the TB Negative pgs. 1-2 **OR** if you are TB Positive you need to ONLY include the TB Positive pgs. 1-2. This will ensure that these same documents will get mapped over.
IF you scanned **ALL** your pages into **ONE** document then you would only upload the **ONE WHOLE** document **but** upload it for **EVERY** Health Clearance & Immunization Category.



ALL documents MUST be either a .pdf, .jpg or .png. AND must be CLEAR and have ALL parts of the document visible. None of the documents or pictures of each document can be cut off or cropped. Your Complio profile will be rejected if ANY of the documents are not labeled correctly, in the right format, completely clear, visible, and all fields are filled in and uploaded to the correct category.

REMEMBER, NO OTHER FORMS OR DOCUMENTS WILL BE ACCEPTED FOR YOUR HEALTH CLEARANCE & IMMUNIZATION CATEGORIES IN COMPLIO!! DO NOT UPLOAD ANY OTHER DOCUMENTS OTHER THAN THOSE PICTURED BELOW!!

Please continue to the next page for instructions on how to properly name each page of your Health Clearance packet.

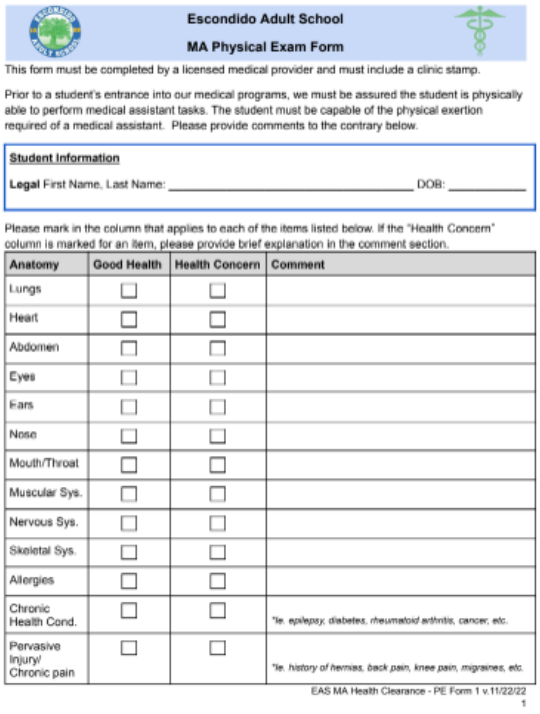
If you are scanning the entire packet as **ONE** document you can skip labeling each individual page! Label the **WHOLE PACKET** as "**MA Immunization Packet pgs. 1-12**" or however many pgs. apply to you

Again, you would just need to upload the **WHOLE** document for **ALL** the Health Clearance & Immunization Categories.

When you scan or take a picture of the pages in your Health Clearance packet make sure you "**Save**" **THESE EXACT PAGES** with the following labels:

MA Student Health Clearance & Immunization Verification Forms

Label: MA PE Pg.1



Escondido Adult School

MA Physical Exam Form

This form must be completed by a licensed medical provider and must include a clinic stamp.

Prior to a student's entrance into our medical programs, we must be assured the student is physically able to perform medical assistant tasks. The student must be capable of the physical exertion required of a medical assistant. Please provide comments to the contrary below.

Student Information

Legal First Name, Last Name: _____ DOB: _____

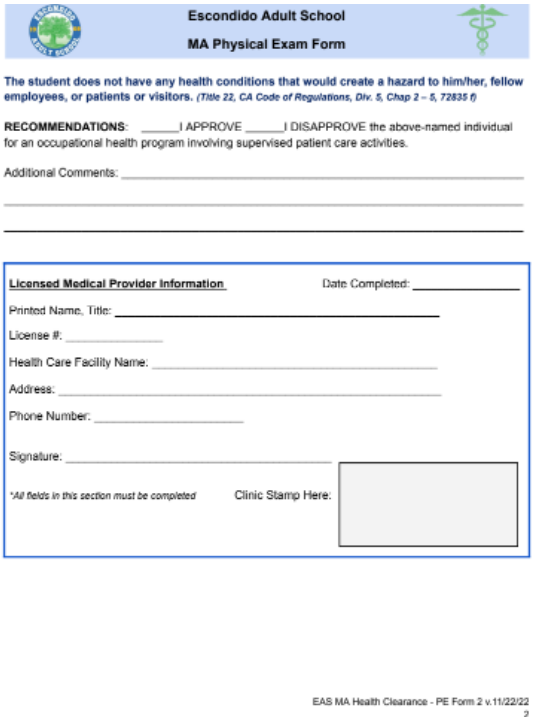
Please mark in the column that applies to each of the items listed below. If the "Health Concern" column is marked for an item, please provide brief explanation in the comment section.

Anatomy	Good Health	Health Concern	Comment
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Mouth/Throat	☐	☐	
Muscular Sys.	☐	☐	
Nervous Sys.	☐	☐	
Skeletal Sys.	☐	☐	
Allergies	☐	☐	
Chronic Health Cond.	☐	☐	*Ie. epilepsy, diabetes, rheumatoid arthritis, cancer, etc.
Pervasive Injury/ Chronic pain	☐	☐	*Ie. history of hernias, back pain, knee pain, migraines, etc.

EAS MA Health Clearance - PE Form 1 v.11/22/22

1

Label: MA PE Pg.2



Escondido Adult School

MA Physical Exam Form

The student does not have any health conditions that would create a hazard to him/her, fellow employees, or patients or visitors. *(Title 22, CA Code of Regulations, Div. 5, Chap 2 – 5, 72835 f)*

RECOMMENDATIONS: _____I APPROVE _____I DISAPPROVE the above-named individual for an occupational health program involving supervised patient care activities.

Additional Comments: _____

Licensed Medical Provider Information Date Completed: _____

Printed Name, Title: _____

License #: _____

Health Care Facility Name: _____

Address: _____

Phone Number: _____

Signature: _____

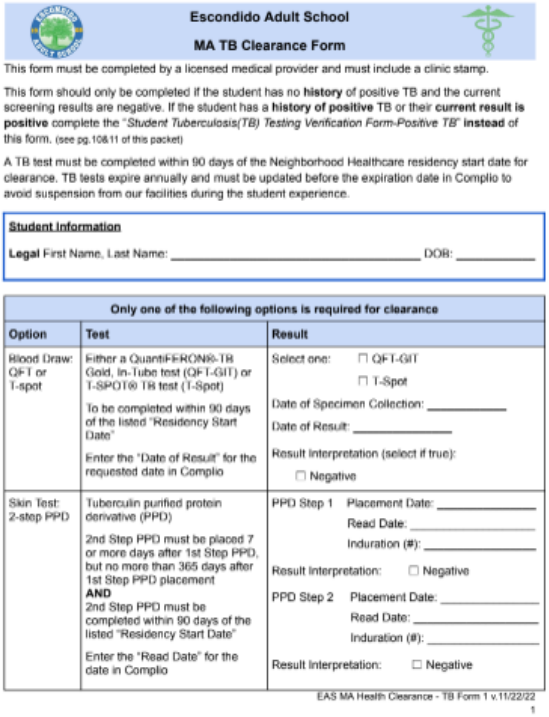
*All fields in this section must be completed

Clinic Stamp Here:

EAS MA Health Clearance - PE Form 2 v.11/22/22

2

Label: MA TB Pg.1



Escondido Adult School

MA TB Clearance Form

This form must be completed by a licensed medical provider and must include a clinic stamp.

This form should only be completed if the student has no **history** of positive TB and the current screening results are negative. If the student has a **history of positive** TB or their **current result is positive** complete the "*Student Tuberculosis(TB) Testing Verification Form-Positive TB*" **instead** of this form. (see pg.10&11 of this packet)

A TB test must be completed within 90 days of the Neighborhood Healthcare residency start date for clearance. TB tests expire annually and must be updated before the expiration date in Complio to avoid suspension from our facilities during the student experience.

Student Information

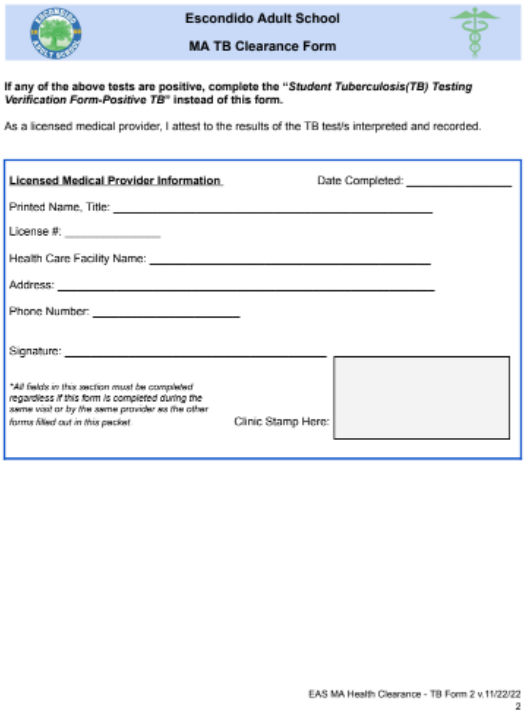
Legal First Name, Last Name: _____ DOB: _____

Only one of the following options is required for clearance		
Option	**Test**	**Result**
Blood Draw: QFT or T-spot	Either a QuantiFERON®-TB Gold, In-Tube test (QFT-GIT) or T-SPOT® TB test (T-Spot) To be completed within 90 days of the listed "Residency Start Date" Enter the "Date of Result" for the requested date in Complio	Select one: ☐ QFT-GIT ☐ T-Spot Date of Specimen Collection: _____ Date of Result: _____ Result Interpretation (select if true): ☐ Negative
Skin Test: 2-step PPD	Tuberculin purified protein derivative (PPD) 2nd Step PPD must be placed 7 or more days after 1st Step PPD, but no more than 365 days after 1st Step PPD placement **AND** 2nd Step PPD must be completed within 90 days of the listed "Residency Start Date" Enter the "Read Date" for the date in Complio	PPD Step 1 Placement Date: _____ Read Date: _____ Induration (#): _____ Result Interpretation: ☐ Negative PPD Step 2 Placement Date: _____ Read Date: _____ Induration (#): _____ Result Interpretation: ☐ Negative

EAS MA Health Clearance - TB Form 1 v.11/22/22

1

Label: MA TB Pg.2



Escondido Adult School

MA TB Clearance Form

If any of the above tests are positive, complete the "*Student Tuberculosis(TB) Testing Verification Form-Positive TB*" instead of this form.

As a licensed medical provider, I attest to the results of the TB test/s interpreted and recorded.

Licensed Medical Provider Information Date Completed: _____

Printed Name, Title: _____

License #: _____

Health Care Facility Name: _____

Address: _____

Phone Number: _____

Signature: _____

*All fields in this section must be completed regardless if this form is completed during the same visit or by the same provider as the other forms filled out in this packet

Clinic Stamp Here:

EAS MA Health Clearance - TB Form 2 v.11/22/22

2

Please make sure you Label or "Name" THESE EXACT PAGES of the Health Clearance Packet documents as follows:

MA Student Health Clearance & Immunization Verification Forms

Label: MA Immunization Pg.1

Escondido Adult School

Student Immunization Verification Form

This form must be completed by a licensed medical provider (MD, DO, NP, PA, or RN only) and must include a clinic stamp. The student must demonstrate either full immunization or appropriate titer(s) demonstrating immunity (if applicable).
The student may decline HBV, MMR, Varicella, Tdap/TD, or annual influenza by indicating on this form and completing the declination form. If the student has not yet completed the required doses for vaccination or does not have a titer, they must complete the declination form. Employment in the medical field will require specified vaccinations and immunizations.

Student Information

Legal First Name, Last Name: _____ DOB: _____

Lifetime Immunization or Titer History

Requirement	Immunization *Only complete if series is complete* OR	Titer(s) *Only complete if titer result demonstrates immunity*
Hepatitis B (HBV) ☐ Student does not meet requirement or declines and will complete the declination form *Non-immune titers cannot be accepted*	Select one: ☐ 2-dose or ☐ 3-dose series Date 1: _____ Date 2: _____ Date 3: _____ ☐ Booster completed after non-immune titer Booster (if applicable) Date:_____	Quantitative Hepatitis B Surface Antibody titer Result Date: _____ Result(# Value):_____ Positive/Immune Reference Range: _____ Check this box to confirm student's immunity: ☐ Positive, student demonstrates immunity to HBV
Varicella ☐ Student does not meet requirement or declines and will complete the declination form *Non-immune titers cannot be accepted*	2-dose series Date 1: _____ Date 2: _____ ☐ Booster completed after non-immune titer Booster (if applicable) Date:_____	Quantitative Varicella IgG Antibody titer Result Date: _____ Result(# Value): _____ Positive/Immune Reference Range: _____ Check this box to confirm student's immunity: ☐ Positive, student demonstrates immunity to Varicella

Label: MA Immunization Pg.2

Escondido Adult School

Student Immunization Verification Form

Lifetime Immunization or Titer History

Requirement	Immunization *Only complete if series is complete* OR	Titer(s) *Only complete if titer result demonstrates immunity*
Measles, Mumps, Rubella (MMR) ☐ Student does not meet requirement or declines and will complete the declination form *Non-immune titers cannot be accepted*	2-dose series Date 1: _____ Date 2: _____ ☐ Booster completed after non-immune titer Booster (if applicable) Date:_____	Measles IgG Antibody titer Result Date: _____ Result(# Value):_____ Positive/Immune Reference Range: _____ Check this box to confirm student's immunity: ☐ Positive, student demonstrates immunity to Measles Mumps IgG Antibody titer Result Date: _____ Result(# Value):_____ Positive/Immune Reference Range: _____ Check this box to confirm student's immunity: ☐ Positive, student demonstrates immunity to Mumps Rubella IgG Antibody titer Result Date: _____ Result(# Value):_____ Positive/Immune Reference Range: _____ Check this box to confirm student's immunity: ☐ Positive, student demonstrates immunity to Rubella

Label: MA Immunization Pg.3

Escondido Adult School

Student Immunization Verification Form

Immunization History

Requirement	Immunization
Tetanus/Diphtheria/Pertussis (Tdap) or Tetanus/Diphtheria (TD) Booster ☐ Student does not meet requirement or declines and will complete the declination form	1-dose lifetime Date: _____ 1-dose within the last 10 years Vaccine Type (Select one): Tdap Date: _____ TD Date: _____
Annual Influenza ☐ Student does not meet requirement or declines and will complete the declination form	Administered between 8/1-3/31 yearly Date: _____ *Expires on 7/31 yearly*

Medical providers:
- Please verify the COVID vaccination card/s or record/s.
- The card or record must have the student's legal name and medical provider stamp or signature

Requirement	Immunization
COVID-19 Initial Series ☐ Student does not meet requirement or declines and will complete the declination form	2-dose series of Pfizer or Moderna **OR** 1-dose of Johnson & Johnson/Janssen Vaccine Type (Pick One): ☐ Pfizer-BioNTech or ☐ Moderna Date 1: _____ Date 2: _____ ☐ Johnson and Johnson/Janssen Date: _____
COVID-19 Booster ☐ Student does not meet requirement or declines and will complete the declination form	Pfizer or Moderna booster vaccine **OR** 1-dose booster of Johnson and J/J Vaccine Type (Pick One): ☐ Pfizer-BioNTech ☐ Moderna ☐ Johnson & J/J Date 1: _____ Date 2 (if applicable): _____

Label: MA Immunization Pg.4

Escondido Adult School

Student Immunization Verification Form

As a licensed medical provider (MD, DO, NP, PA, or RN only), I attest to the results of the immunizations and/or vaccines interpreted and recorded on the attached forms.

Licensed Medical Provider Information Date Completed: _____

Printed Name, Title: _____ License #: _____

Health Care Facility Name: _____

Address: _____

Phone Number: _____

Signature: _____

**All fields in this section must be completed* Clinic Stamp Here:

Please make sure you Label or "Name" THESE EXACT PAGES of the Health Clearance Packet documents as follows:

MA Student Health Clearance & Immunization Verification Forms

Label: MA TB Pos. Pg.1

Escondido Adult School

MA TB Clearance Form - Positive History or Current Result

This form should only be completed if you have a history of positive TB (i.e., tested positive on a previous TB screening test) or have a current positive result. You must have a chest x-ray within the last 36 months that shows **no signs** of active TB and demonstrate no signs or symptoms of active TB to be eligible for clearance.

A licensed medical provider must review the student's answers to the Tuberculosis Symptom Questionnaire and complete the History of Positive TB and Licensed Medical Provider Information sections of the form.

Student Information

Legal First Name, Last Name: _____ DOB: _____

Student Tuberculosis Symptom Questionnaire

This section must be completed by the student and be reviewed by a licensed medical provider.

In the past year, have you experienced any of the following symptoms NOT associated with a specific illness (i.e. cold or flu) and lasting more than 3 weeks?

Symptom	NO	YES	Comments
Cough	☐	☐	
Blood streaked sputum	☐	☐	
Unexplained weight loss	☐	☐	
Night sweats (excluding menopause)	☐	☐	
Fever	☐	☐	

Student Signature: _____ Date: _____

A licensed medical provider must complete the next page of this document.

Label: MA TB Pos. Pg.2

Escondido Adult School

MA TB Clearance Form - Positive History or Current Result

This section must be completed by a licensed medical provider.

PPD Conversion:

Date: _____ Induration (#): _____ Interpretation: **Positive**

QFT/T-spot Conversion:

Date: _____ Interpretation: **Positive**

Chest X-Ray:

Date Completed: _____ Date Read: _____

Result: **Negative, no signs of active TB**

For the Chest X-Ray, enter the "Read Date" for the date in Complio

Licensed Medical Provider Attestation

By signing my signature below in the Licensed Medical Provider Information box, I am certifying that the student does not demonstrate any signs or symptoms of active TB within the 36 months.

Licensed Medical Provider Information Date Completed: _____

Printed Name, Title: _____

License #: _____

Health Care Facility Name: _____

Address: _____

Phone Number: _____

Signature: _____

**All fields in this section must be completed regardless if this form is completed during the same visit or by the same provider as the other forms filled out in this packet.*

Clinic Stamp Here:

Label: MA Decline Pg.1

Escondido Adult School

Student Vaccine Declination Form

Student Information

Legal First Name, Last Name: _____ DOB: _____

During your student experience you may be exposed to transmissible diseases. You may be at risk of acquiring infection with Hepatitis B, Measles, Mumps, Rubella (MMR), Varicella (Chicken Pox Vaccine), Tdap (Tetanus, Diphtheria & Pertussis), and other known/not yet known transmissible diseases.

For your safety, it is strongly recommended that you complete all recommended vaccinations prior to your student experience.

However, if you choose not to obtain vaccination for the following transmissible diseases and still participate in your student residency experience, you are knowingly assuming the risk of exposure to these diseases.

Declination of Recommended Vaccinations

Initial next to the vaccine you are declining and sign and date the declination below.

Student Initials	Declination
	I have declined the Hepatitis B (HBV) vaccine.
	I have declined the Measles, Mumps, Rubella (MMR) vaccine.
	I have declined the Varicella (Chicken Pox) vaccine.
	I have declined Tdap (Tetanus, Diphtheria, & Pertussis) vaccine.

Please read the following statement and if you agree, sign and date below.

I, _____ understand that there are inherent risks in a healthcare setting and that Escondido Adult School or Neighborhood Healthcare cannot eliminate these risks regardless of the care taken to avoid them. I have had the opportunity to obtain the recommended vaccinations prior to starting my student experience. I understand that not having the recommended vaccines, I am at risk of acquiring diseases from various pathogens. By choosing to participate in this experience, I voluntarily take responsibility for this risk. I understand that as a student, I am not eligible for workers' compensation and agree to hold Escondido Adult School & Neighborhood Healthcare and its affiliates harmless.

Student Signature: _____ Date: _____

Label: MA Decline Pg.2

Escondido Adult School

MA COVID-19 and/or Influenza Declination Form

Student Information

Legal First Name, Last Name: _____ DOB: _____

During your student experience you may be exposed to transmissible diseases. You may be at risk of acquiring the COVID-19 virus and/or the Influenza virus.

For your safety, it is strongly recommended that you complete all recommended vaccinations prior to your student experience.

If you choose not to obtain vaccination for COVID-19 and/or Influenza and still participate in your student experience, you are knowingly assuming the risk of exposure to this virus.

For the safety of employees and patients at Neighborhood Healthcare, you must comply with the following masking requirements.

Initial each statement below, indicating your agreement with each statement.

Student Initial	Declination and Compliance Statement
	I do not have the COVID-19 vaccine and agree to wear a mask and comply with any and all directives for non-vaccinated persons at ALL times while at the Neighborhood Healthcare facility.
	I do not have the Influenza vaccine and agree to wear a mask and comply with any and all directives for non-vaccinated persons at ALL times while at the Neighborhood Healthcare facility

I understand that there are inherent risks in a healthcare setting and that Escondido Adult School or Neighborhood Healthcare cannot eliminate these risks regardless of the care taken to avoid them. I have been given the opportunity to obtain the recommended vaccinations prior to starting my student experience. I understand that by declining the recommended vaccines, I am at risk of acquiring disease from the pathogens above. By choosing to participate in this experience, I voluntarily take responsibility for this risk. I understand that as a student, I am not eligible for worker's compensation and agree to hold Escondido Adult School & Neighborhood Healthcare and its affiliates harmless.

Student Signature: _____ Date: _____